M&M Cartage
Family-owned since 1972

Employee Benefits Guide

Plan Year: January 1, 2023 - December 31, 2023

Prepared by:

FOUNDATION RISK PARTNERS

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Eligibility

ELIGIBILITY

As an M&M Cartage employee, you are eligible for benefits if you work at least 30 hours per week. The eligibility period for enrollment is first of the month following 30 days from date of hire.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

If your spouse is employed and has coverage available to them through their employer, your spouse is not eligible to be covered under M&M Cartage's Employee Benefit Plan. If at any time your spouse becomes employed by an employer who does provide health care coverage, they will need to enroll in their employer's plan as they will no longer be eligible under M&M Cartage's Employee Benefit Plan.

Employees covering dependents for medical, dental and/or vision will be required to provide documentation to certify that the dependent(s) meets the plan eligibility definition. A dependent is an eligible spouse or child under age 26.

Once your benefit elections become effective, they remain in effect until the end of the plan year. You may only change coverage within 30 days of a qualified life event.

401(k) eligibility period for enrollment is on the 1st day of the month after working 90 days.

QUALIFIED LIFE EVENT

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits.

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

For more information, please contact **Stacey Murphy at (502) 456-4526 ext. 236.**

How To Enroll

Please sign on to Paycom at Paycom.com > Login > Employee

Here is a direct link to the employee login page: **https://www.paycomonline.net/v4/ee/web.php/app/login**

If you have a smart phone, please download the Paycom app. You can complete enrollment through the app, if you prefer.

- Your username is the Paycom code assigned to M&M Cartage, 0XL97, plus your four digit badge number. For example, if your badge number is 1234, then your username is 0XL971234 (Please note that the only letters in your username are the XL, the rest are numbers). You are able to change this username to your email address once you are logged in. If you have already changed your username, please enter that when logging in.
- If you have forgotten your password for Paycom, please try to reset it by answering the security questions that you set up.
- Once you are logged in to Paycom, go to your notifications center. Please click on the bell icon located in the top right hand section of your Paycom screen. Click on 2023 Benefits Enrollment and begin your enrollment process.
- Please be sure to have beneficiary and dependent information handy while completing enrollment.
- Please be sure to finalize, sign, and submit your enrollment.
- If you have trouble logging in to Paycom or need assistance with the enrollment process, please contact the HR Manager, Stacey, at ext. 236.
- Once you have completed enrollment and made your elections, you will not be able to change them until the next Open Enrollment period, unless you have a valid qualifying event.
- Your enrollment must be finalized and submitted with 3 weeks of your hire date. If you do not respond or enroll, we will assume you are waiving all benefits. You will then not be able to enroll unless there is a valid qualifying event, or during Open Enrollment.

Medical Insurance
UMR / Policy # 76-411431

	Buy-Up PPO	Base HSA
Annual Deductible* (Single/Family)	$2,500 / $5,000	$3,000 / $6,000
Out-Of-Pocket Maximum* (Single/Family)	$4,000 / $8,000	$4,000 / $8,000
Schedule of Benefits		
Preventive Care*	Covered in full, no deductible	Covered in full, no deductible
Primary Care Office Visit*	$30 copay	20% after deductible
Specialist Office Visit*	$50 copay	20% after deductible
Inpatient Hospital Services*	30% after deductible	20% after deductible
Hospital / Alternative Care Facility*	30% after deductible	20% after deductible
Urgent Care*	30% after deductible	20% after deductible
Emergency Room Care (Copay waived if admitted.)	30% after deductible	20% after deductible
Retail Prescription Drugs (30-day supply)*	$10 / $30 / 50%	20% after deductible
Mail Order Prescription Drugs (90-day supply)*	$20 / $60 / $125	N/A

*Per ACA guidelines these costs apply to your out-of-pocket limit.
These are in-network benefits; for out-of-network benefits please see the complete benefit summary.

Plan Cost	HSA Contribution
For premium rates, please refer to the chart on page 5.	M&M Cartage contributes to employee's Health Savings Accounts (HSA) $500 a year for single and $1,000 a year for family.

SPOUSAL WAIVER

If your spouse is employed and has coverage available to them through their employer, your spouse is not eligible to be covered under the M&M Cartage Employee Benefit Plan. If at any time your spouse becomes employed by an employer who does provide health care coverage, they will need to enroll in their employer's plan as they will no longer be eligible under M&M Cartage's Employee Benefit Plan.

To locate a network provider in your area, go to: www.myuhc.com

Select Choice Plus network.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

January 1st – December 31st, 2023
Wellness Program Guide

Onsite Health Solutions
Since 1993
WELLNESS AT WORK

M&M Cartage
Family-owned since 1972

The goal of the M&M Cartage Wellness Program is to support you in your commitment to a healthy lifestyle. This guide explains what you need to do to live healthier and earn your incentive for participation.

Steps to Wellness

Wellness Plan

Your health and wellness are very important to us at M&M Cartage! By participating in M&M Cartage's Wellness Program, you are provided the opportunity to earn a premium discount on your medical insurance. Our Wellness Program consists of a biometric screening, health risk assessment, and other activities you will be able to earn points for through the WellRight platform. WellRight makes it fun and easy to reach health goals and thrive at any age. Take steps to engage and adopt healthier behaviors.

All information collected for the wellness plan will be kept confidential and will be subject to HIPAA reporting requirements. No one at M&M will have access to employee specific data and results.

Wellness Plan Breakdown

Our 2023 program will start on January 1, 2023 and end on December 31, 2023. This is a **7500+** point challenge, and for each level you achieve, you will earn a discount on your medical insurance premium.

Tier 1	Tier 2	Tier 3	Tier 4
7500+ Points	5000 Points	3500 Points	1500 Points

Weekly insurance premiums based on WellRight points/status

WellRight Status	Tier 1	Tier 2	Tier 3	Tier 4
PPO Plans				
Employee Only	$32.10	$39.02	$45.95	$52.87
Employee/Spouse	$85.59	$92.51	$99.43	$106.35
Employee/Child(ren)	$77.16	$84.08	$91.01	$97.93
Family	$154.09	$161.02	$167.94	$174.86
H.S.A Plans				
Employee Only	$1.95	$8.87	$15.79	$22.71
Employee/Spouse	$47.77	$54.69	$61.62	$68.54
Employee/Child(ren)	$44.98	$51.90	$58.83	$65.75
Family	$100.64	$107.56	$114.48	$121.41

Steps to Wellness

Step 1: M&M Wellness Portal

After registration has been completed, the URL to our custom site is https://mandmwellness.wellright.com/

This link will take you straight to your login page.

If you are new to the program and wish to be invited, or your registration link has expired, email Catie@healthyworksite.com and request to be added to the program.

Step 2: EARN YOUR POINTS

Earn your points by **December 31, 2023** by completing any combination of the wellness activities list on the following page.

More activities may be added throughout the year.

Activity	Points
Completion of Health Risk Assessment- (Age Gage)must complete between Jan 1 2023 and Dec 31 2023	**500**
Nicotine Test- You will automatically receive these points if your test is negative at the 2023 biometric screening- date of this screening is TBD.	**400**
Completion of Biometric Screening- Points will be rewarded if you participated in the biometric screening in 2023 or complete a biometric screening anytime throughout the year (Jan 1 2023 and Dec 31 2023).	**800**
Annual w/PCP, Dental Exam (up to 2), Flu Shot, Colonoscopy, Mammogram, Pap, Skin Check w/ Dermatologist, Vision Exam w/ Optometrist, Osteoporosis Check, Completion of Covid Vaccine (2 dose), Covid Booster	**300/each** **There are no maximum number of points in this category. Complete as many as necessary based on gender/age. Preventive screenings will be accepted if Date of Service is between Jan 1, 2023 and Dec 31, 2023.**
Blood Donation	**50/each** **You can earn a maximum of 300 points in this category. Must take place between Jan 1, 2023 and Dec 31, 2023.**
University Courses https://mandmwellness.wellright.com/	**50/each** **You can earn a maximum of 500 points in this category. Must take place between Jan 1, 2023 and Dec 31, 2023.**
Community Service: Volunteer for non-profit for a minimum of 2 hours per event	**100/per event** **You can earn a maximum of 200 points in this category. Must take place between Jan, 1 2023 and Dec, 31 2023.**
Monthly Wellness Challenges https://mandmwellness.wellright.com/	**200/month** **You can earn a maximum of 2400 points in this category. A new wellness challenge will be available each month Jan-Dec 2023. Personal Wellness Challenges do not earn points.**
CPR/First Aid -Can be a new certification or proof that certification is current.	**150** **You can earn a maximum of 150 points in this category.**
	Continued on next page

Activity	Points
Gym Usage- For each month, you can upload a print out from your fitness facility showing you checked in at least 12x that month. For each month of at least 12 workouts submitted, you will receive 100 points.	**100/month** **This challenge will run from Jan 1, 2023 through Dec 31, 2023. Total of 12 months for a maximum of 1200 points.**
Monthly Step Challenge (average of 7,000 steps/day. Device MUST be registered for WellRight in order to earn points.	**150/month** **This challenge will run from Jan 1, 2023 through Dec 31, 2023. Total of 12 months for a maximum of 1800 points.**

Submission Instructions for Activity Completion and Preventative Screenings

You must provide documentation showing completion of activities. Documentation can be in the form of an EOB (Explanation of Benefits), Visit Summary, printout from gym, picture of yourself at event, or any other type of proof of the activity.

There will be instructions included with each challenge on https://mandmwellness.wellright.com/
You will need to upload your documentation. Your submission will show pending approval until your wellness coordinator is able to verify it.

OR if you prefer, you can email it with the info below.

- Email: catie@healthyworksite.com
  Subject Line: M&M Wellness Challenge
  Please include your full name and company name

If you are unable to complete an activity due to a medical condition, please contact Catie at Catie@healthyworksite.com and a reasonable accommodation will be given to you.

ACCOUNT **SETUP**

Complete your account setup

After registration, complete the steps below to setup your account and sign up for challenges. Track your progress through the website, mobile app, fitness devices and text tracking.

STEP 1

Web

1. Log in to view available challenges
2. Hover over a challenge and click the “i” icon to learn more
3. Track a challenge by hovering over it , clicking “Track”

STEP 2

Mobile App

1. Download the WellRight app in the Apple or Google Play store
2. Click on existing challenge tiles or click on the “+” icon to add a personal challenge.
3. Track a challenge by tapping on it and clicking on “Track”

STEP 3

Device Setup

1. On the home page, go to the Device Menu
2. Select your device
3. Sign in to grant access
4. WellRight can now automatically track progress for you

STEP 4

Text Reminders

1. Add your mobile number to your account homepage
2. Hover over a challenge and click ”i” to set your text reminders
3. Reply to the text to track your progress

For help, contact support@healthyworksite.com

TEXT **TRACKING 101**

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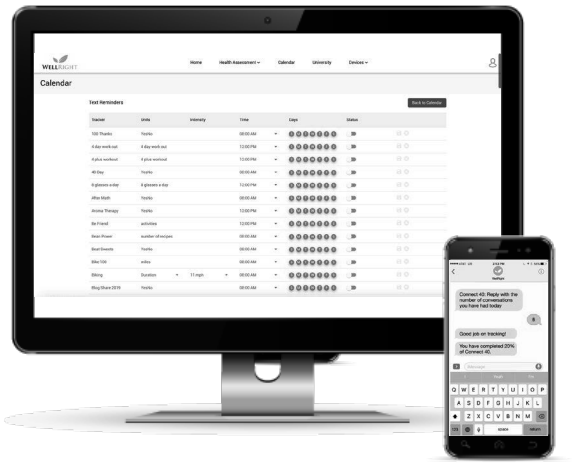


Register your mobile number

Log in on the web and click on your name

Enter your mobile number and click save

"YES"

Respond "Yes" to verification text message

Update your text notification schedule

Click on "Calendar"

Select "Text Reminders"

Customize your text reminders

Modify at any time*

* To do so click on the Homepage, hover over the challenge you want to modify, then click on the information ("i") icon.

Tips and Tricks for Text Tracking

- **Skip:** Reply "SKIP" to skip a specific challenge's text reminder.
- **Stop:** Reply "STOP" to turn off text messaging. Users can turn back on in user profile settings.
- **Ignore 3 texts in a row:** By not responding to 3 text reminder prompts in a row, text reminders will automatically be turned off.
- **Help:** Reply "HELP" to be directed toWellRight Support.

For help, contact support@healthyworksite.com

WELLRIGHT

Maximize Your Savings

By Considering These Best Practices

90 Day Supply / Retail Pharmacy: To help cut costs and increase convenience to you, TrueScripts allows 90-day prescriptions to be filled at retail pharmacies nationwide. To obtain a 90-day prescription, have your prescribing provider call into your pharmacy of choice with the updated prescription; an office visit is typically not required.

Generic Medications: Generic medications provide quality, cost-effective alternatives to brand medications. Generic equivalents work the same way in the body and have the same ingredients, strength, dosage, and form as their brand-name counterparts. Unless otherwise directed by your doctor, it is a good idea to use generic equivalents when possible.

Over-the-Counter (OTC) Products: Some brand-name prescription drugs have OTC alternatives that are therapeutically identical and are likely a much lower cost option for treating your condition. When talking to your prescriber, ask if an OTC product is available. TrueScripts will also do our part to identify situations where OTC coverage will benefit both you and your health plan.

Coupons & Copay Cards: Several websites, such as goodrx.com, offer large databases of savings opportunities. Please have your pharmacy check pricing through all sources before checking out. If any of those sources provide greater savings, please select that option and submit your receipt(s) via the Electronic Drug Reimbursement form found at www.truescripts.com/members. The amount paid will be applied to your deductible and/or out of pocket, based upon plan structure.

Manufacturer websites also list additional copay assistance programs on their websites. Keep in mind that only copay cards can be used *in addition to* your TrueScripts coverage.

Shop Around: Drug prices can vary significantly by pharmacy location. Use our Drug Price Lookup tool to compare drug prices at more than 70,000 pharmacies nationwide. Please note that prices are subject to change without notice at any time.

Take Medications as Directed: Not taking your medication as directed by your doctor can lead to health complications. This includes missing doses, ending prescribed medicines early, or not taking them at all. If you are unable to afford your medication, please speak freely with your physician to discuss other options.

TrueScripts™

Amazing Care at your fingertips!

Introducing

TEXT & LIVE CHAT

memberportal.truescripts.com **Get Started!**

Whether you want to receive money-saving updates or need to ask time-saving questions, our new text message and live chat services put the power in your hands!

SMS Text - receive notifications for savings opportunities, confirmation of refills, plan updates, and more!

- Register in the TrueScripts Member Portal at memberportal.truescripts.com. Upon registering, check the box, ☐ **I agree to receive text messages from TrueScripts**
- You can also opt to receive emails by checking ☐ **I agree to receive emails from TrueScripts**
- If you are already registered in the portal, you can opt to receive text messages and emails by going to "My Profile" in the drop-down window at the top right corner of your screen. Here, you will see the option to check one or both boxes and update your profile.
- You may also call TrueScripts to opt into our SMS texting services.

Live Chat - get assistance with a claim, drug pricing information, explanation of benefits, and more!

- Register or log-in to your TrueScripts Member Portal. Once logged in, you will see the Live Chat button at the bottom right-hand corner of your screen. Just click to get started!
- To help us best assist you, you will be asked to submit a few pieces of information.
- Within less than a minute after clicking "Submit," you will be connected with a live TrueScripts professional.

Our team is available via live chat, text message, or standard phone call at the number below during our regular business hours of Monday - Friday, 8AM - 6PM (ET).

We look forward to serving ***you!***

TrueScripts™ *Amazing Care*

We are Experts in Prescription Benefits.
Questions? Please call and speak to a care specialist who will answer your questions. **812-257-1955**

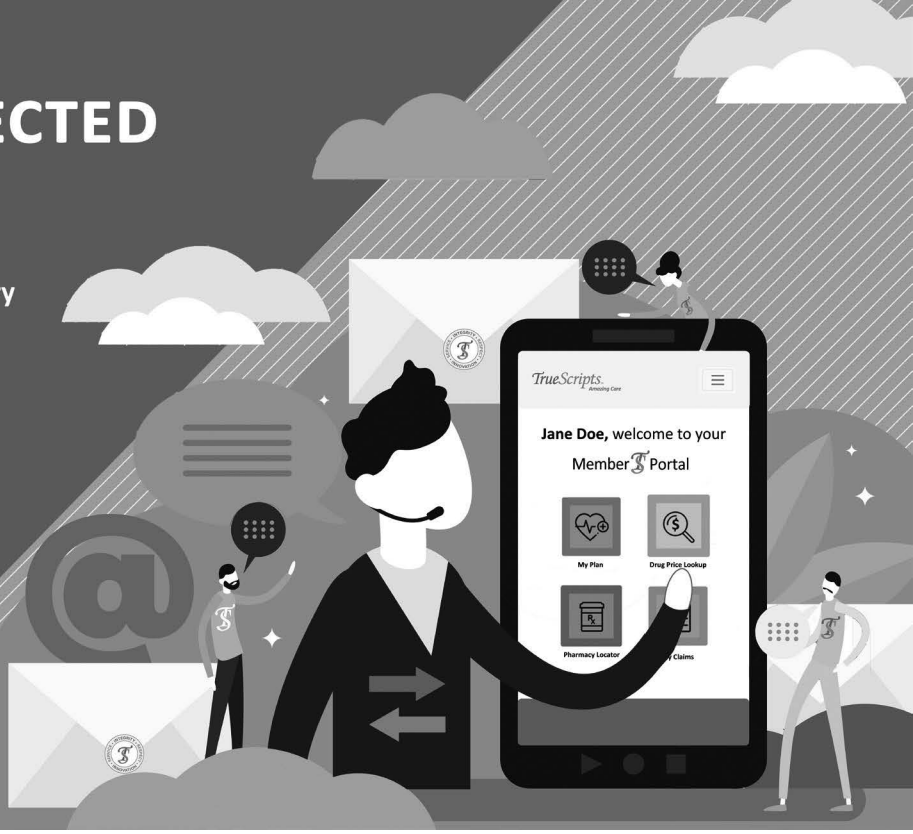
KEEPING YOU CONNECTED

Member Portal

- Your Personal Plan Information & Claims History
- Real-Time Drug Price Lookup
- Pharmacy Locator
- Other Member Forms & Resources
- 24 Hours a Day, 7 Days a Week

Scan above
or
Enter below

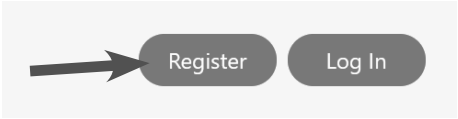
memberportal.truescripts.com Get Started!



Follow these instructions to register for the TrueScripts Member Portal:

- **Enter the URL above into your web browser or click "Get Started" if viewing this document electronically. You can also scan the QR code from your mobile device to begin the registration process.**

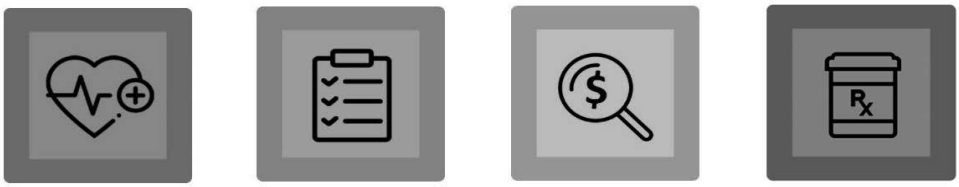
- **On the Member Portal landing page, choose "Register" from the top navigation bar.**



- **Enter your personal information to complete the registration process.**
Note that you will need to have your Member ID card readily available

- **Check your email to verify and complete your account set-up.**

- **Once inside the portal, quickly access important information and helpful resources from your Member Dashboard. The Drug Price Lookup and Pharmacy Locator tools will help you find the pharmacies nearest you with the best price for your medications.**



If you have any questions along the way, please call us at the number below.
Our team is prepared to provide you with *Amazing Care!*

TrueScripts™ *Amazing Care*

We are Experts in Prescription Benefits.
Questions? Please call and speak to a care specialist who will answer your questions. **844-257-1955**

ELECTRx
Pharmacy Benefit Strategists

M & M Cartage
International Mail Order Program

How to Use the Elect RX International Mail Order Program

M & M Cartage is offering a great option for you to save money on certain **brand name** prescription drugs through the **Elect Rx International Mail Order Program**. This program is known as Personal Importation or PI. You can order your brand name drugs from Canada, New Zealand, Australia and England using the same "brick and mortar" pharmacies that people in these countries use for their medications. Those in the traditional plan will have a **$0 co-pay** on certain brand medications and those in the high deductible plan will benefit from significantly lower prices **(30% to 80% less!)**. HD plan members cannot use HSA funds to reimburse themselves because of IRS rules. Here's how you can begin using the program.

1. On the back of this document is a list of brand name prescription drugs that are offered through the Elect Rx Personal Importation Program (PI). Review this list and see if any of the medications you are currently taking can be filled through the Personal Importation (PI) Program. We are constantly updating this list. Call Customer Service if you do not see your drug listed. You can order a 90-day supply of any brand name medication that is eligible for dispensing through this program.
2. Members can enroll by calling **1-855-353-2879**. A Customer Service Representatives will complete the enrollment process and order for you. You will be asked several questions related to your medical condition including any known allergies and a list of the prescription drugs you are currently taking. **You should have those prescription drugs with you when you make the call.**
3. Have your Physician prepare a prescription for a **90-day supply** with **3 refills** and FAX it to the Elect Rx Toll Free Number at **1-833-353-2879**. Again, traditional plan members will have a **$0 co-pay** on each 90-day fill including subsequent refills and HD plan members will have a **$0 co-pay** on each 90-day fill including subsequent refills after they have met their deductible. You will receive an automated reminder notification of a pending renewal/refill on or around day 60 of the last 90-day supply shipped. Shipping takes 10-15 business days from the date of completed requirements (Faxed Rx from Physician and initial call to customer service from the member /employee). Specialty drugs are normally limited to a 30-day supply. **Tip: Have a 30-day supply on hand to allow for plenty of delivery time.**

Elect Rx Customer Service: 1-855-ElectRx
Monday-Friday – 8:30AM to 4:30PM

Elect Rx Physician Fax: 1-833-ElectRx

Customer Service Email: info@electrx.com

M & M Cartage
Elect Rx Drug Formulary September 2021
Personal Importation Program (90-day supplies)
Brand Medications Available Through Elect Rx

Elect Rx Customer Service: 1-855-353-2879
Open 8:30AM to 4:30PM M-F
Physician Fax: 1-833-353-2879

ELECTRx
Pharmacy Benefit Strategists

Please call Customer Service if you do not see your Drug listed!

Drug Name	Drug Name	Drug Name	Drug Name	Drug Name	Drug Name	Drug Name
Actemra	Ciprodex Ear Drops	Estrogel Gel	Kaletra*- PA/G	Nuvaring - PA/G	Segluromet	Trelegy Ellipta
Advair Diskus - PA/G	Combigan	Eucrisa Ointment	Kazano - PA/G	Odefsey	Selzentry*	Tremfya*
Advair Inhaler	Combipatch	Evotaz	Kisqali**	Ofev 100MG*	Serevent	Tresiba
Afinitor*- PA/G	Combivent	Exelon Patches - PA/G	Kombiglyze XR	Ofev150MG**	Seroquel XR - PA/G	Tribenzor - PA/G
Aklief Cream	Complera*	Fareston - PA/G	Kynmobi	Olumiant*	Silenor - PA/G	Trintellix
Alecensa**	Copaxone	Farxiga	Lacrisert	Omnaris Nasal Spray	Simbrinza	Triumeq*
Alomide	Corlanor	Ferriprox	Lantus	Ongentys	Simponi*	Trizivir - PA/G
Alphagan P - PA/G	Cortifoam	Fetzima	Latuda	Onglyza	Skyrizi	Trulicity
Alrex	Cosentyx	FIASP	Lenvima**	Opsumit*	Soliqua	Tudorza Pressair
Alvesco	Cosopt PF	Flovent	Levemir	Oracea - PA/G	Soolantra - PA/G	Tykerb
Anoro Ellipta	Creon	Flovent HFA Inhaler	Lexiva*- PA/G	Oralair	Soriatane - PA/G	Uceris - PA/G
Apidra	Crinone Gel	Forteo	Lialda - PA/G	Orencia	Spiriva	Velphoro
Aptiom	Cuprimine - PA/G	Fosamax D	Linzess	Orilissa	Spiriva Respimat	Veltassa
Arnuity Ellipta	Daliresp	Frova - PA/G	Locoid Lipocream - PA/G	Orthovisc	Sprycel*	Vemlidy
Asacol HD - PA/G	Daraprim	Genotropin	Lonsurf	Otezla*	Steglatro	Verzenio**
Asmanex	Delstrigo	Genvoya*	Lotemax Eye Drops- PA/G	Oxytrol	Steglujan	Viberzi
Astagraf XL	Denavir Cream	Gilenya*	Lupron Depot	Ozempic	Stelara*	Victoza
Atripla*	Descovy*	Gilotrif*	Lynparza**	Pentasa	Stiolto	Viibryd
Atrovent	Dexilant	Gleostine	Mayzent - 0.25MG*	Pifeltro	Stivarga	Vimpat
Aubagio*	Dipentum	Glyxambi	Mayzent - 2MG*	Plaquenil - PA/G	Stribild*	Viracept
Avonex	Divigel	Grastek	Mekinst - 0.5MG*	Pradaxa	Striverdi	Votrient*
Azelex	Dovato	Humalog	Mekinst - 2MG*	Premarin	Sustiva - PA/G	Vraylar
Azilect - PA/G	Duaklir Pressair	Humatrope	Mestinon 180MG - PA/G	Prempro	Sutent - 12.5MG*	Vyzulta
Azopt	Duavee	Humira*	Migranal - PA/G	Prestalia	Sutent - 25MG**	Xadago
Banzel*	Dulera	Humulin	Mirvaso	Prevacid Solutab - PA/G	Sutent - 50MG*	Xarelto
Baqsimi	Duobrii	Ibrance*	Motegrity	Prezcobix	Symbicort Inhaler- PA/G	Xeljanz
Basagler	Dymista - PA/G	Imbruvica*	Multaq	Prezista*	Symtuza*	Xeljanz XR
Benlysta	Edarbi	Incruse Ellipta	Myleran	Promacta*	Synarel	Xeloda - PA/G
Bepreve	Edarbyclor	Inlyta*	Myrbetriq	Pulmicort - PA/G	Synjardy	Xenazine - PA/G
Besivance	Edecrin	Intelence	Natazia	Qtern	Taclonex - PA/G	Xenical
Betoptic S	Edurant	Intrarosa	Nesina - PA/G	Qvar Inhaler	Tafinlar*	Xerese Cream
Bevespi Aerosphere	Eliquis	Invega - PA/G	Neulasta	Qvar Redihaler	Taltz*	Xifaxan - 200MG
Biktarvy*	Elmiron	Invirase	Neupogen	Rebif	Tarceva*- PA/G	Xifaxan - 550MG
Binosto	Emcyt	Invokamet	Neupro	Relpax - PA/G	Tasigna*	Xigduo XR
Blephamide	Emtriva	Invokana	Nevanac	Renagel - PA/G	Tasmar - PA/G	Xiidra
Bosulif*	Enablex - PA/G	Iressa*	Nexavar**	Restasis	Tazorac Cream - PA/G	Xtandi
Breo Ellipta	Enbrel*	Isentress*	Nexium Packets	Rexulti	Tazorac Gel	Zelapar
Brilinta	Entocort - PA/G	Jakafi*	Nitrolingual - PA/G	Ridaura	Tecfidera*- PA/G	Zeposia*
Briviact	Entresto	Janumet	Nocdurna	Rinvoq	Tekturna - PA/G	Ziana Gel - PA/G
Bydureon	Entyvio*	Janumet XR	Norditropin	Rybelsus	Tivicay* Toujeo	Zolinza**
Bystolic	Envarsus	Januvia	Noritate	Sancuso	Solostar Toviaz	Zomig Spr Zortress*-
Cambia	Epiduo Forte	Jardiance	Novolin	Santyl Ointment	Tradjenta	PA/G Zovirax Cream -
Canasa - PA/G	Epivir HBV - PA/G	Jentadueto	Novolog	Saphris		PA/G
Cardura XL	Esbriet	Jublia Topical Solution	Nubeqa	Savaysa	Transderm-Scop - PA/G	Zyclara - PA/G
Cimzia	Estring	Juluca*	Nucala		Travatan Z - PA/G	

PA/G - Prior Authorization Required by TrueScripts - Generic Available - TrueScripts Needs to Check Price of Generic
*This medication will only be dispensed as a one month supply due to the high cost of this medication.
**This medication will only be dispensed as a one month supply due to the high cost of this medication & must be paid in full before shipping.

Contact Us

855-353-2879
FAX: 833-353-2879

276 South Logan St.
Elyria, OH 44035

Info@electrx.com

ELECTRx
Pharmacy Benefit Strategists

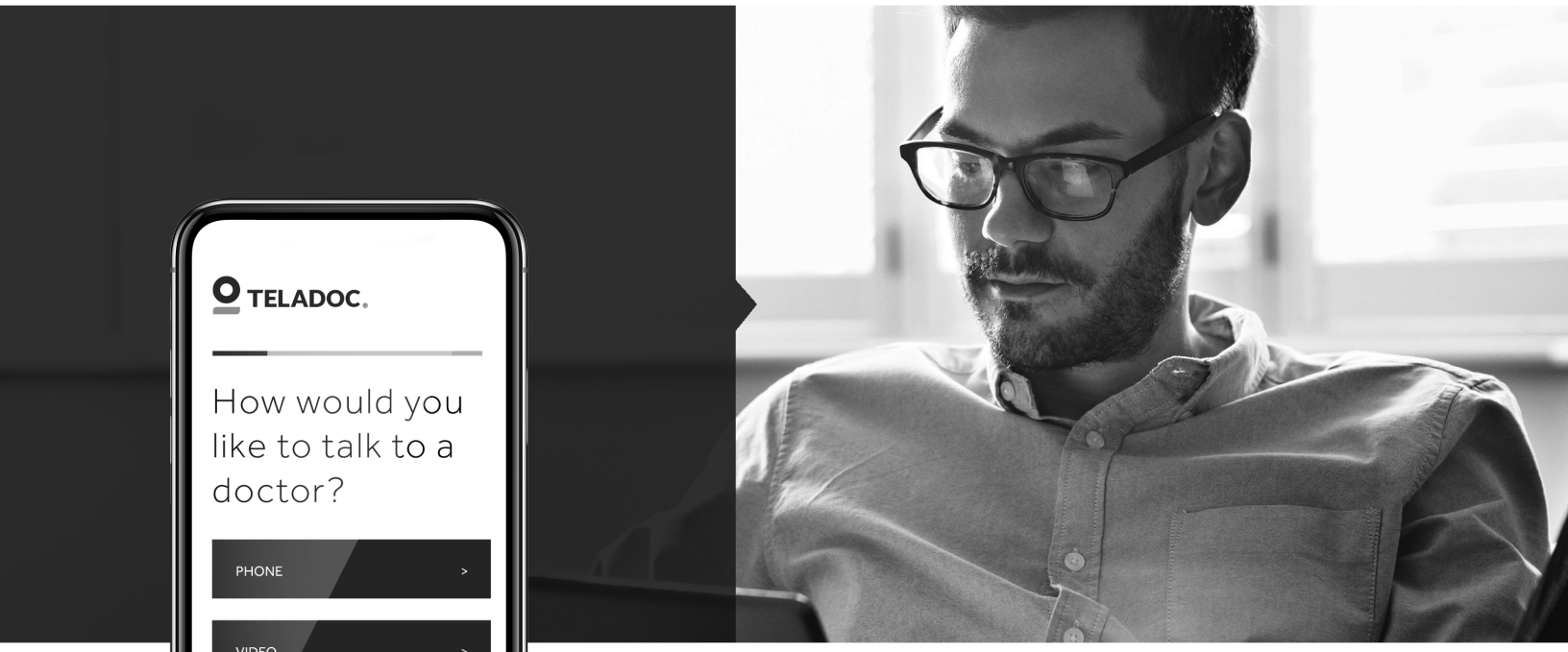
ElectRx specializes in insulin and diabetic medications. Talk to us today to have your medications mailed directly to your home at a $0 copay or significantly reduced cost, if enrolled in the HSA plan.

ElectRx Offers the Following:

- Apidra
- Basaglar
- Bydureon
- Farxiga
- Humalog
- Humulin
- Invokamet
- Invokana
- Janumet
- Januvia
- Jardiance
- Jentadueto
- Kombigylze
- Lantus
- Levemir
- Novolin
- Novolog
- Onglyza
- Ozempic
- Rybelsus
- Segluromet
- Soliqua
- Steglatro
- Synjardy
- Toujeo SoloStar
- Tradjenta
- Tresiba
- Trulicity
- Victoza
- Xigduo

ElectRx is a leading U.S. based group of pharmacy benefit consultants. We lower the cost of prescriptions for you.

TELADOC. | M&M Cartage



You've got Teladoc

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to talk to a U.S.-licensed physician for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

Feel better

The doctor will diagnose symptoms and send a prescription if necessary

Group ID: 177470

CancerCARE

Right Care. Right Time. Right Place.

A Benefit Specialized In Dealing with Cancer

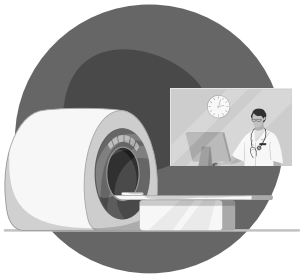
The CancerCARE Program is an additional benefit, provided by your health plan, that focuses on helping members diagnosed with cancer. Our passionate medical team will oversee your cancer treatment and ensure the optimal treatment path with proven results is being followed. **We are your cancer advocates and will strive to lead you and your dependents to survivorship!**

Day One Help

We are available to help you from the day of your diagnosis and beyond. You can register for the program at any point in your cancer journey to gain access to our resources and support. Registration is available through our website or by phone.

Personalized Care

Once you are part of the program, **a dedicated nurse will be with you every step of the way.** This nurse will be available to answer any questions you might have as well as make sure you are **receiving ideal treatment for your diagnosis.**



National Resources

Through CancerCARE, **you will have access to some of the best doctors, hospitals, and technology nationwide.** We will work with your local oncologist to make sure all treatment options are considered, not just local ones.

Expert Medical Team

Our medical staff has decades of experience treating cancer and we pride ourselves on staying up-to-date with the latest cancer treatments and technology. Each medical staffer has unique cancer expertise and background.

+1 877 640 9610 cancermanagement@cancercareprogram.net cancercareprogram.net

KISx Card: Surgery. Imaging. Simplified.

Join to learn more about Surgery and Imaging benefits that are available to you!

Text

"cartage"

to 64554

Or SCAN this to join!

Normal text messaging rates apply.
Text "STOP" to opt out. Text "HELP" for help.
Receive up to 2 messages per month.

M&M CARTAGE

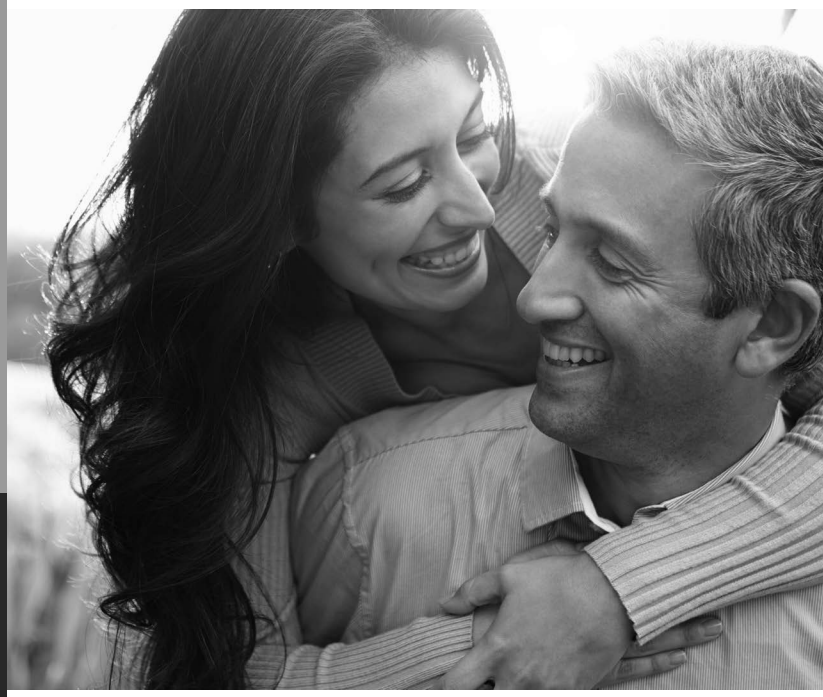
SURGERY. SIMPLIFIED.

To help you be healthy.

The KISx Card is a surgery & imaging program that your employer has made available to you for the most common surgical & imaging procedures. Some of the most typical procedures through The KISx Card include: Orthopedic, General Surgery, Colonoscopies, MRI, CT and PET Scans. If you utilize the program, you will receive your procedure at ***NO COST**.

KISxCard™

Keep It Simple Surgery



CALL

Call a KISx Card Nurse at 877-GET-KISX to find out more about your procedure and how the program works. We will assist you in finding the right facility nearby.

SCHEDULE

A KISx Card Nurse will help schedule your procedure. Upon scheduling, they will then provide you with a voucher to take to your initial consultation.

PROCESS

BE HEALTHY

After you have had your procedure through a KISx Card Provider, your KISx Card Nurse will follow up to make sure you are making a full recovery. We want to make sure you are getting better so you can live a healthy life!

SAVE

You will *NOT pay anything out of pocket for choosing a KISx Card provider. Every aspect of your procedure is covered through the KISx Card.

HOW IT **WORKS?**

Before seeking In-Network Providers through your health plan, just call a KISx Card Nurse regarding your elective procedure. By choosing a KISx Card provider, you will always pay *$0.

CALL, SCHEDULE, SAVE
BE HEALTHY

GET IN **TOUCH**

Phone: 877-GET-KISX

Email: info@getKISx.com

*HSA Plans require first dollar coverage from patient before procedure up to IRS Minimum, before program incentives are received.

If you believe you need any procedure, Call the KISx Card first!

877-GET-KISX

Talk to a KISx Card Nurse About a Procedure:
Call - 877-GET-KISX
Email - Info@getkisx.com

Providers To Verify Benefits:
Patient is *NOT* to Provide Insurance Information for procedure.

Send Claims to Info@getkisx.com
Fax: 855-351-7521

SURGERY **SIMPLIFIED**

By choosing a KISxCard provider you will always pay **$0 out of pocket***

877-GET-KISX

SCHEDULE

SAVE

KISx Card is the first program to ever exist that directly rewards YOU for taking action!

KISx Card covers over 400 different procedures

- Orthopedic Surgery
- General Surgery
- Colonoscopies
- MRI, CT & PET Scans

Just call, text, or email your personal nurse concierge who is waiting to schedule your procedure today!

www.getkisx.com

Please make sure to sign-up for push notifications and download the Spruce Health App: https://spruce.care/KISXCARD so we can stay in touch!

**HSA Plans require first dollar coverage from patient before procedure up to IRS Minimum, before program incentives are received.*

Health Savings Account (HSA)
My Benefit Wallet

A Health Savings Account (HSA) is an account that can be funded by you, your employer, or both, with tax-exempt dollars. Funds from the account can help pay for eligible medical expenses that are not covered by your insurance plan including deductible, coinsurance, and even dental and vision services.

ADVANTAGES OF AN HSA:

- Money can be invested much like 401(k) funds
- You can change your HSA contribution amount during any payroll period
- Unused money is not forfeited at the end of the year and is carried forward
- The account is yours to keep so that you can take it with you if you change jobs or retire
- If you have any money remaining after your retirement, you may withdraw it as cash without penalty

Keep in mind, an HSA can only be used in conjunction with a High-Deductible Health Plan, which for M&M Cartage is the Base HSA Health Plan.

Any funds used on non-qualified expenses or subject to taxation and a 20% penalty from the IRS.

CONTRIBUTIONS

- The maximum amount that can be contributed in 2023 is $3,850 for a single contract and $7,750 for a family.
- Individuals 55 and over can make an additional $1,000 catch-up contribution annually.

M&M Cartage will contribute $500 for single / $1,000 for family to your HSA each year if you participate in the HSA-Compatible Health Plan (Base HSA Plan). Please keep in mind the total annual contribution to your HSA cannot exceed the IRS limits listed above.

To see a list of eligible HSA expenses, please visit **https://hsastore.com/HSA-Eligibility-List.aspx**

How It Works

When visiting a physician, hospital, or other facility:

- When arriving for your appointment, provide them with your health insurance card.
- After your visit, your claim will be submitted to your insurance carrier for processing
- After the health care provider has received notification from your insurance carrier that the claim has been processed, you will receive a billing statement outlining the balance for which you are responsible.
- You then use your bank card/HSA check to pay for these expenses.

When going to the Pharmacy:

- When picking up your medication, provide them with your health insurance card.
- The pharmacy will run it through their system and provide you with a balance due.
- You then use your bank card/HSA check to pay for these expenses at that time.

YOU SAVE…

One option for employee contributions is via pre-tax payroll deduction through a Section 125 plan. One advantage of this plan is your contributions are not subject to individual or employment taxes. This means if you contribute $1,000 of your gross pay into the HSA, the impact on your net pay is about $700 since you did not have to pay tax on your HSA contributions. In this example, you would save about $300.

Dental Insurance
Delta Dental / Policy # 688540

Benefit Design	In-Network*
Annual Deductible (Individual/Family)	$50 / $150
Annual Maximum (per person)	$1,250
Waiting Period	12 months on major services
Diagnostic and Preventive Services Includes cleaning, fluoride treatments, sealants and x-rays	Covered at 100%
Minor Services Minor restorative - fillings, crown repair, endodontic services - root canals, oral surgery services - extractions & dental surgery, dental repair	20% after deductible
Major Services Periodontics services - to treat gum disease, major restorative services - crowns, fixed prosthodontic repair and removal, relines & rebase - to dentures, adjust partial or complete dentures, prosthodontic services - bridge, implants and dentures	50% after deductible
Orthodontia Covers Children	Not Covered

*As noted above these are in-network benefits; for out-of-network benefits please see the complete benefit summary.

What do I need when I go to the dentist?
Nothing. You do not need an ID card or a claim form to receive treatment. However, at your first visit after your dental coverage takes effect, it would be helpful if you provide your dentist with your group number and member ID number for their records.

Plan Cost	Premium Per Pay
Employee Only	$4.86
Employee + Spouse	$9.92
Employee + Child(ren)	$9.63
Family	$15.95

To locate a network provider in your area go to: www.deltadentalky.com

Select Premier network.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Vision Insurance
Delta Dental / Policy # 68854V

Delta Vision 130	
Benefit Design	**In-Network***
Frequency Exam Lenses Frames	 12 months 12 months 24 months
Exam	$10 copay
Frames	$130 allowance
Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular	$25 copay
Medically Necessary Contact Lenses**	Covered in full
Elective Conventional Lenses**	$130 allowance

*As noted above these are in-network benefits; for out-of-network benefits please see the complete benefit summary.
**Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same period, nor can any unused amount be carried over to the following benefit period.

Plan Cost	Premium Per Pay
Employee Only	$1.45
Employee + Spouse	$2.91
Employee + Child(ren)	$3.11
Family	$4.97

To locate a network provider in your area go to: www.deltadentalky.com

Select VSP network.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Stay informed about your dental benefits with Member Portal

Stay current on your dental benefits with Delta Dental's easy-to-use Member Portal.

This secure online tool is designed to give you 24/7 access to important information regarding your dental benefits, including:

- Eligibility information
- Current benefits information (such as how much of your yearly benefit has been used to date)
- Specific claims information, including what has been approved and when it was paid

The site also allows you to sign up for electronic delivery of Explanation of Benefits (EOB) statements, print claim forms and identification cards, and browse oral health information.

All users must first register to gain access to the Member Portal. Privacy of your online benefit information is assured through highly secure encryption technology.

Get started today

To start taking advantage of this innovative tool, follow these simple steps:

1. Visit www.memberportal.com.
2. Select "Sign Up" on the home page.
3. Complete the required fields under "Validate Membership" and click "Create Account."
   NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. In many cases, the member ID is the same as the subscriber's Social Security number.
4. Complete required fields and follow the on-screen instructions.
5. Return to the home screen and log in using the unique username and password you created.

If you need further assistance, contact Member Portal support at 866-356-0301.

Stay informed about your DeltaVision® benefits on vsp.com

Learn more about your vision benefits and access claims on vsp.com.

It's that simple! Once you create an account, you can review your benefit information, access personalized eligibility and plan coverage details, and print a Member Vision Card.

Create an account

1. Visit **vsp.com**
2. Click on CREATE AN ACCOUNT at the top of the page.
3. Enter the last 4 digits of the primary member's SSN or Member ID Number.
4. Continue to complete all required fields.
5. Click on CREATE MY ACCOUNT to complete process.

Mobile App - Delta Dental's mobile app provides the ability to search for a Delta Dental Premier® or Delta Dental PPO™ dentist in your area, check your claims and coverage information on the go, get estimated cost ranges for common dental services, and access a mobile ID card that you can show your dental office.

Basic Life and AD&D Insurance
One America / Policy # 617706

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment. Our company provides Basic Life and AD&D insurance to all eligible employees at no cost to you.

This benefit includes:
- **Basic Life:** One times annual basic earnings up to a maximum of **$10,000.**
- **AD&D:** One times annual basic earnings up to a maximum benefit of **$10,000.**
- **REDUCTION SCHEDULE:** Employee 65% at age 65; 50% of original amount at age 70; benefits terminate at retirement.

Voluntary Life and AD&D Insurance
One America / Policy # 617706

Employees may purchase additional Life and AD&D insurance. Employees may only enroll in voluntary life and AD&D coverage as new hires. Any amounts elected over the guaranteed issue require evidence of insurability.

- Employees may elect $10,000 - $500,000, up to 5 times basic annual earnings.
- The guaranteed issue for newly eligible employees under age 65 is $200,000.
- Employees may elect Spousal Life at $5,000 - $250,000, up to 50% of the employee amount.
- The guaranteed issue for newly eligible spouses under age 65 is $50,000.
- Employees may elect up to $10,000 for each dependent child.
- Employee and spouse rates are based on the insurance you choose and the applicable age band **(these premiums will be reflected in your online enrollment system).**
- **REDUCTION SCHEDULE:** Employee 67% at age 70; 45% at age 75; benefits terminate at retirement. Spouse 67% at employee age 70; 45% at age 75. Benefits terminate at employee retirement.

Voluntary Disability Insurance
One America / Policy # 617706

The goal of a Disability Insurance Plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Certain disabilities are not covered if the cause of the disability is traceable to a condition existing prior to your effective date. The premiums for both STD and LTD will be reflected in your online enrollment system.

Short-Term Disability (STD):
- 60% of covered weekly earnings up to $1,150
- Elimination period before benefits begin:
  14 days accident / 14 days illness
- Payable to 26 weeks

Long-Term Disability (LTD):
- 60% of base monthly earnings up to $5,000
- Elimination period before benefits begin:
  180 days or the end of the maximum STD benefit
- Payable for up to SSNRA

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Call Your ComPsych® GuidanceResources® program anytime for confidential assistance.

Call: **855.387.9727**
Go online: **guidanceresources.com**
TDD: 800.697.0353
Your company Web ID: **ONEAMERICA3**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Free Online Will Preparation

Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

ONEAMERICA®

ONEAMERICA® is the marketing name for the companies of OneAmerica. OneAmerica markets ComPsych services. ComPsych is not an affiliate of OneAmerica and is not a OneAmerica company.

Your ComPsych® GuidanceResources® Program

CALL ANYTIME
Call: **855.387.9727**
TDD: 800.697.0353
Online: **guidanceresources.com**
Your company Web ID: **ONEAMERICA3**

Peace of Mind When Traveling

Travel assistance

Emergencies happen, but help is now only a phone call or email away. On Call International® offers a suite of services to help you in your time of need — from small inconveniences like losing your luggage to life-threatening situations — all delivered with a caring, human touch.

Find comfort in knowing you and your loved ones are protected by the Travel Assistance benefit when traveling more than 100 miles from home for business or leisure. The Travel Assistance benefit protects you when covered under a OneAmerica® company group life insurance policy. It also extends coverage to your spouse, domestic partner and children (under 21 or 25 and living at home as a full-time student) even when they are traveling without you. The Travel Assistance benefit requires no additional premium; however, exclusions do apply.

Medical assistance and transportation services

Pre-trip plan to provide up-to-date information regarding required vaccinations, health risks, travel restrictions and weather conditions.

Medical monitoring and review of documentation utilizing professional case managers and medical professionals to ensure appropriate care is received.

24-hour nurse help line to provide clinical assessment, education and general health information.

Replacement of prescriptions and eyeglasses that have been lost or stolen by consulting with the prescribing provider to transfer prescription to or arranging an appointment with a local provider.

Medical, behavioral or mental health, dental and pharmacy referrals to assist in finding care providers and medical facilities.

Coordination of benefits by requesting health information from the participant and attempting to coordinate benefits during an active travel assistance case.

Emergency medical evacuation to arrange and coordinate air and/or ground transportation and medical care during transportation to the nearest hospital where appropriate care is available.

Medical repatriation to arrange the transport of the participant with a qualified medical attendant, if medically necessary, to their residence or home hospital.

Return of remains to arrange the transportation of a participant's remains to their home in the event of their death while traveling.

24-hour travel assistance

Travel Assistance is made available through OneAmerica® by an agreement with On Call International®

1-866-816-2103 (US/Canada)

1-603-328-1754 (call collect from other locations)

Email: **mail@oncallinternational.com**

Accident Insurance

Sun Life

M & M CARTAGE CO., INC.

All Eligible Employees

POLICY # 918460

You can purchase this coverage for you and your family. Child coverage is available to age 26.

HELPS YOUR FINANCES AFTER A MISHAP.
When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

PAYS CASH BENEFITS DIRECTLY TO YOU.
Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

ACCIDENT FAST FACTS

Falls *are the leading cause of injuries treated in emergency rooms every year, for people of all ages.*[1]

This coverage pays benefits for accidents that occur off the job.

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here.

DISLOCATIONS	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$4,000	$1,000
Knee or Shoulder	$1,000	$400
Ankle or bones of the foot	$1,000	$300
Elbow or wrist	$800	$400
Collarbone or bones of the hand	$1,600	$300
Finger(s) or toe(s)	$200	$100
Lower jaw	$1,000	$500
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$3,000	$1,500
Skull-depressed	$5,000	$2,500
Skull-simple	$2,500	$1,250
Vertebral processes or Rib	$1,200	$300
Bones of the face, Upper jaw or upper arm	$750	$375
Nose, Heel or Finger	$700	$175
Leg, Vertebrae, Sternum or Pelvis	$1,600	$800
Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap or Elbow	$650	$325
Toe	$250	$125
Coccyx	$400	$200
ADDITIONAL INJURIES		
Eye Injury - surgical repair		$300
Eye Injury - object remove		$65
Paralysis—paraplegia		$25,000
Paralysis—quadriplegia		$50,000
Coma		$20,000
Concussion		$100
BURNS	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$400	$1,000
41-65 square centimeters	$800	$2,000
66-160 square centimeters	$1,200	$6,000
161-225 square centimeters	$1,600	$14,000
More than 225 square centimeters	$2,000	$20,000
Skin graft	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor		$35
Single laceration under 5 cm with sutures		$65
5-15 cm with sutures (total of all lacerations)		$250
Greater than 15 cm with sutures (total of all lacerations)		$500

MEDICAL SERVICES	
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$200
Accident Emergency Treatment, non-emergency room (once per covered accident)	$75
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$25
Physical Therapy (per visit up to 10 visits per covered accident)	$25
Medical Devices	$125
Prosthesis (one)	$500
Blood, Plasma, or Platelet Transfusion	$200
HOSPITAL	
Hospital Admission (once per benefit year)	$1,000
Hospital Confinement (per day up to 365 days per covered accident)	$250
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$1,500
Intensive Care Unit Confinement (per day up to 30 days, payable in addition to any Hospital Confinement benefit)	$500
Ambulance (Ground)	$200
Ambulance (Air)	$1,500
Emergency Room Admission	$150
Family Lodging (per day up to 30 days per benefit year)	$100
Transportation (100 or more miles up to 3 times per covered accident)	$600
Rehabilitation Unit (per day up to 365 days per covered accident)	$150
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$300
Open Surgery	$1,250
Exploratory Surgery or Debridement	$300
Laparoscopic Surgery	$300
Tendon/Ligament/Rotator Cuff Tear	$625
Torn Knee Cartilage	$625
Ruptured/Herniated Disc	$625
EMERGENCY DENTAL	
Emergency Dental extraction	$65
Emergency Dental crown	$200
WELLNESS	
Wellness Screening Benefit (once per benefit year)	$50

LIFE AND DISMEMBERMENT LOSSES*	
Accidental Death	$25,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$100,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$15,000
Loss of one hand, foot, leg, or arm	$7,500
Loss of sight of one eye or loss of one eye	$7,500
Two or more fingers or toes	$1,500
One finger or one toe	$1,500

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment. Dependent children benefits are 20% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

Frequently asked questions

How do I file an accident claim?
If you have an accident after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about the accident and the treatment provided.

What happens once my claim is approved?
The benefit amount you receive will depend on your injury and/or the treatment provided. Remember, benefits are payable only once for each covered accident, unless noted otherwise in the benefit schedule.

Is there a time period that I need to follow?
Injuries and other related benefits due to a covered accident must be diagnosed or treated within a defined period of time from the date of your accident. This could be as few as three days for certain benefits. Please refer to your Certificate for details.

How do I get the Wellness Screening Benefit?
You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests and cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). Our wellness screening benefit claim form can also be downloaded from our website.

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Is my benefit taxable?
If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Accident insurance is a limited benefit policy. The Certificate has exclusions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of your Certificate.

1. "Health, United States, 2016," US Department of Health and Human Services, Table 75.

Rates

Coverage and **weekly** cost for Accident.
Rates are effective as of January 1, 2022.
Accident coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Coverage	Cost per pay period*
Employee	$4.82
Employee + Spouse	$6.50
Employee + Child(ren)	$7.16
Employee + Family	$8.84

*Contact your employer to confirm your part of the cost.

Read the *Important information* section for more details including limitations and exclusions.

Critical Illness Insurance

Sun Life

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.
When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.
Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.
What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

BENEFITS *(You can purchase this coverage at a group rate.)*	
For you	You can choose between **$5,000** and **$50,000** of coverage, in increments of $5,000. No medical questions asked up to the Guaranteed Issue amount of $15,000. Your benefit amount is reduced to 50% at age 70.
For your spouse	If you elect coverage for yourself, you can choose between **$2,500** and **$25,000** of coverage, in increments of $2,500. No medical questions asked up to the Guaranteed Issue amount of $7,500. Not to exceed 50% of your coverage amount. The benefit may be reduced when the employee benefit amount is reduced.
For your child(ren)	If you elect coverage for yourself, you can choose **$2,500** or **$5,000** of coverage. No medical questions asked. Not to exceed 50% of your coverage amount. The benefit may be reduced when the employee benefit amount is reduced. An eligible child is defined as your child from birth to age 26.

M & M CARTAGE CO., INC.

All Eligible Employees

POLICY #: 918460

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*

Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer Noninvasive Cancer (Pays 25%) Skin Cancer (Pays 5%)	
Other Conditions	Complete Blindness Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis	Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma
Childhood Conditions *Applies to dependent children only*	Down Syndrome Cystic Fibrosis Type 1 Diabetes Mellitus Spina Bifida	Cerebral Palsy Cleft Lip/Palate Muscular Dystrophy
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 12 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Frequently asked questions

Do I need to answer any health questions to enroll?

Yes, if you request an amount higher than the Guaranteed Issue amount. If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

What if I have a pre-existing condition?

If you are diagnosed with a covered critical illness within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 12 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. In order to receive benefits for more than one critical illness, there must be at least 6 consecutive months between each diagnosis date. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

How is my benefit taxed?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

CRITICAL ILLNESS FAST FACT

*Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.***

**"What Are Your Odds of a Heart Attack?" health.com, June 2018.

Critical Illness insurance is a limited benefit policy. The certificate has exclusions, limitations and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

Read the *Important information* section for more details including limitations and exclusions.

Rates

Rates are effective as of January 1, 2022.
The chart below shows possible coverage amounts and their **weekly** costs.
Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Employee Critical Illness - Choice 1 Non-tobacco rates
Age and cost - pay period (weekly) premium

Coverage amounts	<30	30-39	40-49	50-59	60-69	70+
$5,000	1.21	1.65	2.68	4.35	6.57	13.96
$10,000	2.07	2.95	5.03	8.35	12.80	27.57
$15,000	2.94	4.25	7.37	12.35	19.03	41.19
$20,000	3.80	5.56	9.71	16.36	25.26	54.80
$25,000	4.67	6.86	12.05	20.36	31.50	68.42
$30,000	5.53	8.16	14.40	24.36	37.73	82.03
$35,000	6.40	9.47	16.74	28.37	43.96	95.65
$40,000	7.26	10.77	19.08	32.37	50.19	109.26
$45,000	8.13	12.08	21.42	36.38	56.42	122.88
$50,000	9.00	13.38	23.76	40.38	62.65	136.50

Employee Critical Illness - Choice 1 Tobacco rates
Age and cost - pay period (weekly) premium

Coverage amounts	<30	30-39	40-49	50-59	60-69	70+
$5,000	1.44	2.22	4.33	7.86	14.12	24.31
$10,000	2.53	4.10	8.33	15.39	27.90	48.27
$15,000	3.63	5.98	12.32	22.91	41.67	72.24
$20,000	4.73	7.86	16.31	30.43	55.45	96.20
$25,000	5.82	9.75	20.30	37.96	69.23	120.17
$30,000	6.92	11.63	24.30	45.48	83.00	144.13
$35,000	8.01	13.51	28.29	53.00	96.78	168.10
$40,000	9.11	15.39	32.28	60.53	110.56	192.06
$45,000	10.21	17.27	36.27	68.05	124.33	216.03
$50,000	11.30	19.15	40.26	75.57	138.11	240.00

Spouse Critical Illness - Choice 1 Non-tobacco rates
Age and cost - pay period (weekly) premium

Spouse rates are based on the employee's age.

Coverage amounts	<30	30-39	40-49	50-59	60-69	70+
$2,500	0.77	0.99	1.51	2.34	3.46	7.15
$5,000	1.21	1.65	2.68	4.35	6.57	13.96
$7,500	1.64	2.30	3.86	6.35	9.69	20.76
$10,000	2.07	2.95	5.03	8.35	12.80	27.57
$12,500	2.51	3.60	6.20	10.35	15.92	34.38
$15,000	2.94	4.25	7.37	12.35	19.03	41.19
$17,500	3.37	4.91	8.54	14.36	22.15	48.00
$20,000	3.80	5.56	9.71	16.36	25.26	54.80
$22,500	4.24	6.21	10.88	18.36	28.38	61.61
$25,000	4.67	6.86	12.05	20.36	31.50	68.42

Spouse Critical Illness - Choice 1 Tobacco rates
Age and cost - pay period (weekly) premium

Coverage amounts	<30	30-39	40-49	50-59	60-69	70+
$2,500	0.89	1.28	2.34	4.10	7.23	12.32
$5,000	1.44	2.22	4.33	7.86	14.12	24.31
$7,500	1.99	3.16	6.33	11.63	21.01	36.29
$10,000	2.53	4.10	8.33	15.39	27.90	48.27
$12,500	3.08	5.04	10.32	19.15	34.78	60.26
$15,000	3.63	5.98	12.32	22.91	41.67	72.24
$17,500	4.18	6.92	14.31	26.67	48.56	84.22
$20,000	4.73	7.86	16.31	30.43	55.45	96.20
$22,500	5.27	8.81	18.31	34.20	62.34	108.19
$25,000	5.82	9.75	20.30	37.96	69.23	120.17

Child(ren) Critical Illness - Choice 1

Coverage amounts	Cost - pay period (weekly) premium
$2,500	0.16
$5,000	0.32

SUMMARY ANNUAL REPORT
FOR M AND M CARTAGE CO., INC. EMPLOYEE BENEFIT PLAN

This is a summary of the annual report for the M AND M CARTAGE CO., INC. EMPLOYEE BENEFIT PLAN, EIN 61-0865101, Plan 501, for period January 1, 2021 through December 31, 2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with SUN LIFE ASSURANCE COMPANY OF CANADA, DELTA DENTAL OF KENTUCKY, TOKIO MARINE and AMERICAN UNITED LIFE INSURANCE COMPANY to pay all claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2021 were $1,016,265.

Because some of these contracts are so-called experience-rated contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2021, the premiums paid under such experience-rated contracts were $104,408, and the total of all benefit claims paid under these experience-rated contracts during the plan year was $89,014.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- Financial information and information on payments to service providers
- Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of M AND M CARTAGE CO., INC., 6220 GEIL LANE, LOUISVILLE, KY, 40219, 502-456-4586. The charge to cover copying costs will be $2.00 for the full annual report or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan, 6220 GEIL LANE, LOUISVILLE, KY, 40219 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)

Full time employees are also eligible for the following benefits:

Holiday Pay:

M&M Cartage Co., Inc. observes eight paid holidays each calendar year: New Years Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Eve and Christmas Day.

Vacation Time:

M&M Cartage Co., Inc. believes that vacation is an important employee benefit, which provides a person time away from work so that they can pursue personal interest and, in general, relax and enjoy their family. Every effort will be made to accommodate employees with respect to their vacation while ensuring an efficient operation is maintained.

Full time employees will be eligible for paid vacation in accordance with the following:

- At 1 year anniversary and after, 5 paid days
- At 3 year anniversary and after, 10 paid days
- At 10 year anniversary and after, 15 paid days
- At 20 year anniversary and after, 20 paid days

Personal Days:

- On your date of hire, you will receive 1 personal day.
- On your 1 year anniversary, you will be awarded 2 personal days.
- On your 2 year anniversary, you will be awarded 3 personal days.
- On your 3 year anniversary, you will be awarded 4 personal days.
- On your 4 year anniversary and after, you will be awarded 5 personal days.

Bereavement Days:

All employees bereaved by the death of an immediate family member may be granted time off up to a maximum of three consecutive days. Normally, the three days will be the day before, day of, and day after the funeral.

Immediate family members include: Spouse, children, parents, parents-in-law, brothers, sisters, grandparents, grandchildren, or any person who legally acted in one of the mentioned capacities, or another relative who lived at the employee's residence.

Documentation must be turned in before bereavement time will be granted.

all of the above needs to be approved by management and is subject to change

Employee Incentives

Clean Inspection Bonus (Drivers)

Level I – Full Inspection $50
Level II – Driver/Walk around $50
Level III – Driver only $25

Performance Bonus (Drivers)

Paid out monthly and based on the days worked in the previous month.
Conditions that apply:

- No call-ins during the previous month
- No accidents in the previous month
- No other performance issues in the previous month
- Must complete monthly safety videos by the end of the previous month

Year of Service Bonus

$100 for every year of service to the company

Referral Bonus Program

Recruit a qualified M&M Employee and earn up to $2000! We are looking for new drivers and employees that meet the following qualifications:

- Positive Attitude
- Time Oriented
- Team Player
- Strong Work Ethic
- Attention to Detail
- Safety Oriented

Payment structure of referral bonus:

You will receive a $2000 bonus to be paid out $500 per quarter over one year, beginning after the new hire's first 90 days of employment. The new hire must remain employed for the entire span of the program for you to receive your full bonus.

First pay period after 90 days $500
First pay period after 180 days $500
First pay period after 270 days $500
First pay period after 360 days $500

401(k) Plan
Ascensus

401(k) Enrollment Guidelines	
Participation	Once you fulfill the 90 day eligibility requirement, you will be automatically enrolled in the M&M Cartage 401(k) Plan and your contribution percentage will be set at 2%.
OPT OUT Period	If you DO NOT want to participate in the 401(k) plan, you MUST OPT OUT. To opt out, you will need to call Ascensus at 1-866-809-8146 within 30 days of your eligibility date. If you do not OPT OUT within 30 days of your eligibility date, your employee contribution will automatically be set to 2% on your eligibility date.
Contribution Match	M&M will match your contribution at 50% up to 6%. The 2% you're automatically enrolled in will be invested into a retirement age based fund. If you would like to increase your contribution, please create an account at http://myaccount.ascensus.com/rplink or contact Ascensus by phone at 1-866-809-8146.
Plan Investment Advisors for Q&A	Please contact the 401(k) advisors at Morgan Stanley at 1-502-394-4006 for information regarding contributions and investment options.

Carrier Contact Information

Benefit	Carrier	Phone Number	Carrier Website
Medical Insurance	UMR	1-513-619-3587	www.myuhc.com
Wellness	OnSite Health	1-800-716-5051	www.mandmwellness.wellright.com
Health Savings Account (HSA)	My Benefit Wallet	1-877-472-4200	www.mybenefitwallet.com
Dental Insurance	Delta Dental	1-502-736-5000	www.deltadentalky.com
Vision Insurance	Delta Dental (VSP)	1-800-877-7195	www.vsp.com
Basic Voluntary Life and AD&D Insurance	One America	1-800-553-5318	www.employeebenefits.aul.com
Voluntary Short and Long Term Disability Insurance	One America	1-800-553-5318	www.employeebenefits.aul.com
Voluntary Accident and Critical Illness Insurance	Sun Life	1-816-474-2345	www.sunlife.com
Employee Assistance Program (EAP)	One America	1-855-387-9727	www.guidanceresources.com
Travel Assistance Program	General Global Assistance	1-866-294-2469	Email: ops@europassistance-usa.com
401k Advisors and Retirement Services	Brett Mahle with Morgan Stanley	1-502-394-4006	Email: brett.mahle@morganstanley.com

Your Main Contact

Pamela Murphy
Sr. Account Manager
PMurphy@FoundationRP.com
502.371.4039

Your account manager is here to:

- Be your day-to-day contact
- Assist with claims and enrollment
- Answer questions about eligibility and billing

Additional Contacts

June Lanham
Sr. Account Executive
JLanham@FoundationRP.com
502.371.4035

Jason Rankin
Account Advisor, SVP
JRankin@FoundationRP.com
502.371.4033

Additional Insurance Services

Insurance can be confusing and stressful. Don't let that keep you from having the appropriate coverage for your family & belongings. Let us help take the stress out of it for you. Our staff is equipped with the tools and knowledge to ensure you have the right coverage options. **Call our main number below or ask your account manager for more information.**

Personal Home & Auto

Medicare Solutions

www.FoundationRP.com | Office: 502.805.3742 | Fax: 502.805.2626

Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 9.61% for 2022), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact: **Denise Hayden or Stacey Murphy.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)
M&M Cartage		61-0865101
5. Employer Address		6. Employer Phone Number
6220 Geil Lane		502-456-4526
7. City	8. State	9. Zip Code
Louisville	KY	40219
10. Who can we contact about employee health coverage at this job?		
Denise Hayden or Stacey Murphy		
11. Phone Number (if different from above)	12. Email Address	
502-456-4526	Denise.hayden@mmcartage.com or Stacey.murphy@mmcartage.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Any employee who works 30 hours or more per week

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Spouse and dependent children

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM
OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility -

INDIANA - Medicaid	KENTUCKY - Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
MICHIGAN - Medicaid	**OHIO - Medicaid**
Website: http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html Phone: 1-855-275-6424	Website: http://www.medicaid.ohio.gov Phone: 1-800-324-8680

TENNESSEE - Medicaid
Website: https://www.tn.gov/tenncare/article/tenncare-medical Phone: 1-855-275-6424

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Menu Option 4, Ext. 61565

U.S Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

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FEDERAL REQUIREMENT NOTICES

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Women's Preventive Care

The Affordable Care Act requires insurance companies to cover additional preventive health benefits for women. Health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012. The eight additional services for women that will be covered are:

- Annual Well-Woman Preventive Care Visit
- Gestational Diabetes Screening
- High-Risk Human Papillomavirus DNA Testing
- Sexually Transmitted Infections Counseling
- HIV Screening and Counseling
- Contraception and Contraceptive Counseling
- Breastfeeding Support, Supplies and Counseling
- Interpersonal and Domestic Violence Screening and Counseling

The Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hour following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights Under the Uniformed Services Employment and Reemployment Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Qualified Medical Support Order (QMCSO)

Federal law requires that medical coverage be provided to an Alternate Recipient in accordance with the requirements of a QMCSO. You are responsible for making sure that any medical child support order relating to your child meets the requirements of a QMCSO. The written requirements and procedures governing QMCSOs may be obtained from the Plan Administrator upon request at no charge.

The Health Insurance Portability and Accountability Act of 1996 HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. The focus of this law was to facilitate the portability of health coverage when employees move from one job to another. HIPAA addresses portability, access and renewability of health coverage and affects all group health plan sponsors. The Act also addresses significant benefit areas including long term care, medical savings accounts and COBRA. The following information focuses on the portability, access and renewability provisions of HIPAA.

A major feature of HIPAA is that it limits the length of pre-existing condition exclusions for coverage to 12 months after enrollment (or 18 months for a late enrollee) for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in any new health plan. If an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care or treatment within 6 months prior to enrolling in the plan, the old condition is not a "pre-existing condition" for which an exclusion can be applied.

Pre-existing condition exclusions cannot be applied to pregnancy, regardless of whether the individual had previous coverage. In addition, a pre-existing condition exclusion cannot be applied to a newborn or adopted child under age 18 as long as the child became 21 covered under the health plan within 30 days of birth or adoption, provided the individual does not incur a subsequent 63 day or longer break in coverage. To prove creditable coverage to offset the exclusion period, each participant is entitled to receive a certificate indicating the period of creditable coverage. Coverage under a health plan that occurs before a 63 consecutive day break in coverage is not counted, unless the state insurance laws require otherwise.

The certification of creditable coverage must be in writing and must specify the period of creditable coverage under the group health plan, including periods of COBRA continuation coverage. Group health plans must provide the written certification: 1) at the time a participant's coverage under the plan ends; 2) at the time COBRA continuation coverage ends; and 3) upon request of the individual within two years after coverage ceases.

Patient Protection and Affordable Care Act ("PPACA") - Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

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FEDERAL REQUIREMENT NOTICES

Important Notice from M&M Cartage About Your Creditable Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with M&M Cartage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **M&M Cartage has determined that the prescription drug coverage offered by the PPO and HSA plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will (or will not) be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will (or will not) be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with M&M Cartage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the Entity/Sender listed below for further information [or call Denise Hayden or Stacey Murphy at (502) 456-4586.] **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through M&M Cartage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2023
Name of Entity/Sender: M&M Cartage

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WELLNESS
BluMine

NOTICE CONCERNING THE EMPLOYEE WELLNESS PROGRAM

Purpose of this Notice: Wellness programs gather information as a necessary component of the services provided. This Notice is offered so you understand what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential.

Our wellness provider: BluMine has agreed to provide wellness services for all full-time employees on the medical plan of M&M Cartage.

What information is collected: Wellness programs often gather health information through voluntary health risk assessments (HRAs) or voluntary biometric screenings to measure physical characteristics (e.g., height, weight, BMI, blood pressure, blood cholesterol, or blood glucose). If you choose to participate in the wellness program, you will be asked to complete:

A. biometric screen, which will include collecting cholesterol, blood glucose, BMI, blood pressure, waist circumference and height and weight and/or;
B. a health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease);

You are not required to participate in the wellness program. However, employees who choose to participate in the wellness program will receive the following incentives:

INCENTIVE	CRITERIA TO EARN INCENTIVE
Point System	Complete a biometric screening and health risk assessment (M&M offers this yearly)
Point System	Range of BMI, blood pressure, cholesterol, glucose etc.

If you are unable to participate in any of the above activities or otherwise are unable to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Stacey Murphy or Denise Hayden at M&M Cartage.

How information will be used: The information and results gathered from information you provide will be used to help you understand whether you or family members are at risk for developing a certain disease or medical condition. With this information you can make an informed decision about what types of follow-up programming you may need. The wellness program provider may use the information you provide to design a wellness program based on identified health risks in the workplace.

Who will receive the information: Personally identifiable health information (PII) that you provide in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

The only individual(s) who will receive your PII is you and BLUMINE program. Your information will not be shared with anyone else.

Maintaining the confidentiality of your information: We are required by law and committed to maintaining the privacy and security of your PII. BluMine will never sell or disclose any of your PII either publicly or to M&M Cartage, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, as expressly permitted by law, or to carry out specific activities related to the wellness program.

You will never be asked or required to waive your legal rights to confidentiality of your health information. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

Appropriate precautions will be taken to prevent unauthorized access to your information. All medical information obtained through the wellness program will be kept separate from your personnel records and information stored electronically will be encrypted. You will be immediately notified in the unlikely event a data breach occurs which involves your PII.

Voluntary Participation: You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Stacey Murphy or Denise Hayden at M&M Cartage.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Plan is required to provide this Notice to you by the privacy rules (the "Privacy Rules") issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Notice describes the practices of the group health plan components of the M&M Cartage Group Benefit Plan (the "Plan") which is a hybrid entity. The Plan can revise this Notice at any time. If the Plan makes any material change to this Notice, you will be provided with a revised Notice. If you have any questions, please contact: Denise Hayden or Stacey Murphy.

Your Protected Health Information - The Privacy Rules only protect certain medical information, which is known as "protected health information" (or "PHI"). Generally, PHI is individually identifiable health information created or received in connection with the Plan that relates to: (1) your past, present or future physical or mental health; (2) providing you with health care; or (3) the past, present or future payment for your care. This Notice only applies to the Plan's PHI.

Our Pledge Regarding Medical Information - The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. A record of the health care claims reimbursed under the Plan is created for purposes of the administration of the Plan. This notice applies to all of the medical records maintained by the Plan. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which your medical information may be used or disclosed. It also describes the Plan's obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to make sure that medical information that identifies you is kept private; give you this notice of the Plan's legal duties and privacy practices with respect to medical information about you; and follow the terms of this notice.

The Plan's Use and Disclosure of PHI - In certain circumstances, the Plan can use or disclose your PHI without your permission. However, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI, require an authorization. The following categories describe the different ways that your PHI can be used.

For Payment. The Plan can use or disclose your PHI in connection with: (1) determining your eligibility benefits; (2) facilitating payment for treatment and services that you received from health care providers; (3) determining the Plan's benefit responsibility; and (4) coordinating coverage. For example, the Plan may tell your health care provider about your medical history so he or she can determine whether a treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan can also disclose your PHI to a utilization review provider, precertification provider, or to another entity (or health plan) to assist with the adjudication, subrogation or coordination of payment for health claims.

For Health Care Operations. The Plan can use or disclose your PHI in connection with other operations that are necessary to run the Plan. For example, PHI may be used in connection with: (1) quality assessment and improvement activities; (2) underwriting, premium rating and other similar activities (however, genetic information cannot be used or disclosed for underwriting purposes); (3) submitting stop-loss (or excess loss) claims; (4) conducting medical review, legal services, audit services, and fraud and abuse detection; (4) business planning, management, and development; and (5) the Plan's general administrative activities.

For Treatment. The Plan can use or disclose your PHI to facilitate medical treatment or services by health care providers, including doctors, nurses, technicians, medical students, or other medical personnel who are taking care of you. For example, information about your prior prescriptions can be disclosed to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

To Business Associates. The Plan can contract with individuals or entities known as "Business Associates" to perform various functions or services on its behalf. To perform these functions or services, a Business Associate will have access to, and may use and disclose, your PHI, but only after they enter into an agreement with the Plan to implement appropriate safeguards intended to protect your PHI (i.e., a "Business Associate Agreement"). For example, after entering into a Business Associate Agreement the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

As Required by Law. The Plan can disclose your PHI when it is required by federal, state or local law. For example, the Plan can disclose your PHI when required to do so by federal or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan can use or disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However, disclosures can only be made to those able to help prevent the threat.

To the Company. For the purposes of administering the Plan, your PHI may be disclosed to certain employees who will generally only use or disclose your PHI to perform administration functions for the Plan or as required by the Privacy Rules. Your PHI cannot be used for employment purposes without your authorization.

More Stringent State Laws. In certain situations, the Plan may be required to comply with state laws that have requirements that are more stringent than those described in this Notice.

Special Situations

Organ and Tissue Donation. If you are an organ donor, the Plan can disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the U.S., armed forces or a foreign military, the Plan may disclose your PHI as required by military authorities.

Workers' Compensation. The Plan can disclose your PHI in connection with workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. The Plan can disclose your PHI for public health activities, such as those which involve: (1) preventing or controlling disease, injury or disability; (2) reporting births and deaths; (3) reporting child abuse or neglect; (4) reporting reactions to medications or problems with products; (5) notifying people of recalls of products; (6) notifying people who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and (7) notifying the appropriate government authority if it is believed you have been the victim of abuse, neglect or domestic violence, and if you agree to the disclosure or it is required or authorized by law.

Health Oversight Activities. The Plan can disclose your PHI to a health oversight agency for activities, authorized by law, that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. These activities include audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan can disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute. However, efforts must have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan can disclose your PHI if requested by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, the Plan are unable to obtain the victim's authorization; (4) about a death that is believed to be the result of criminal conduct; or (5) about certain criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan can disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan can also disclose your PHI to a funeral director if necessary to carry out his or her duties.

National Security and Intelligence Activities. The Plan can disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan can disclose your PHI to the correctional institution or law enforcement official if necessary for the institution: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. The Plan can disclose your PHI to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

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NOTICE OF PRIVACY PRACTICES

Other Disclosures

Legal Representatives. The Plan will generally disclose your PHI to individuals authorized by you, or to your legal representative if you provide the Plan with written notice/authorization and supporting documents (e.g., power of attorney). However, the Plan is not required to disclose your PHI to your legal representative if the Plan reasonably believes that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by this person, or treating this person as your legal representative could endanger you; and (2) in the Plan's professional judgment, it is not in your best interest to treat this person as your legal representative.

Spouses/Family Members. The Plan will generally send all mail to the employee covered under the Plan, including mail relating to his or her family members covered under the Plan (e.g. use and denial of benefits). If someone covered under the Plan requested restrictions or confidential Communications (described later in this Notice), and if the HIPAA Privacy Officer agreed to the request, the Plan will send mail as provided by the request.

Authorizations. Uses or disclosures of your PHI that are not described in this Notice will only be made with your written authorization. You can revoke a written authorization at any time if the revocation is in writing. Written revocations are only effective for future uses and disclosures and will not be effective for PHI that may have been used or disclosed (in reliance upon your written authorization) prior to receiving your revocation.

Your Rights

Inspecting and Copying PHI. You have the right to inspect and copy certain PHI that may be used to make decisions about your benefits under the Plans. To inspect and copy this PHI, you must submit your request in writing to the HIPAA Privacy Officer. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. The Plan can deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to your PHI, you can request that the denial be reviewed by submitting a request in writing to the HIPAA Privacy Officer.

Amending PHI. If you believe that certain PHI that is maintained by the Plan is incorrect or incomplete, you have the right to request an amendment as long as the PHI is maintained by the Plan. You can request an amendment, by submitting a written request in writing (along with the reason for your request) to the HIPAA Privacy Officer. Your request may be denied if: (1) it is not in writing; (2) it does not include a valid reason to support the request; (3) it requests an amendment to PHI that is not maintained by the Plan, was not created by the Plan (unless the person or entity that created the PHI is no longer available to make the amendment, or is not PHI that you are permitted to inspect and copy; or (4) it requests an amendment to PHI that is accurate and complete. If your request is denied, you can file a statement of disagreement in writing with the HIPAA Privacy Officer, and then any future disclosures of the disputed PHI will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. However, an accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures that you authorized; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must provide for a time period for the disclosures of not longer than 6 years and may not request disclosures made more than six years before the date you make your request. Your request must indicate the form in which you would like to receive the disclosures (e.g., paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, you may be charged for the costs of providing the disclosures to you. You will be notified of the cost involved and may choose to withdraw or modify your request at that time before any costs are incurred.

Requesting Restrictions. You have the right to request a restriction on uses and disclosures of your PHI that the Plan normally would use or disclose for treatment, payment, or health care operations, or would disclose to someone involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not to disclose PHI about a surgery. The Plan is generally not required to agree to your request. However, if your request is denied, the Plan will honor the restriction until you revoke your request or you are notified of the denial. You must send a written request for restrictions to the HIPAA Privacy Officer. Your request must contain: (1) the PHI you want to limit; (2) whether you want to limit the Plan use, disclosure, or both; and (3) to whom you want the limits to apply (e.g., disclosures should not be made to your spouse).

Requesting Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will accommodate reasonable requests if you provide clear information that the disclosure of all or part of your PHI could endanger you. You must send a written request for confidential communications to the HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. You will not be asked the reason for your request.

Breach Notification. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your "unsecured" PHI.

Paper Copy of This Notice. You can ask the Plan for a paper copy of this Notice any time.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Plan or the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201.You will not be penalized for filing a complaint.

Changes to This Notice

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you, as well as any information the Plan receives in the future. A copy of the current notice will be posted on the website where other information about the Plan is located. The notice will contain on the first page, in the title section, the effective date.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain our records of the care that the Plan provided to you.

Conclusion

The use and disclosure of medical information by the Plans is regulated by a federal law known as HIPAA and the Privacy Rules under HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the Privacy Rules. The Privacy Rules will supersede any discrepancy between the information in this notice and the Privacy Rules.

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Notes Page

Offices in:

Kentucky | Indiana | Ohio

502.805.3742
www.FoundationRP.com